oshpd Office of Statewide Health Planning and Development

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Minutes
Joint Meeting of
California Health Policy and Data Advisory Commission
and
Health Data and Public Information Committee
August 22, 2008

The meeting was called to order by Vito Genna, Chair, at approximately 9:34 a.m., at 400 R Street, Sacramento. A quorum (defined as 50 percent plus one) was in attendance.

Present:

Vito J. Genna, Chairperson
William Brien, MD
Marjorie Fine, MD
Janet Greenfield, RN
Sonia Moseley, CANP
Reza Karkia, DBA, ACFEI, CHS-III
Joe Corless, MD, FAAP
Corinne Sanchez, Esq.
Jerry Royer, MD, MBA

Absent:

Adama Iwu
Kenneth Tiratira

HDPIC Committee: Darryl Nixon; Pamela L. Lane, MS, RHIA; Jacquelyn Paige; Teri Smith O'Rourke; Denise Hunt, RHIA; Vickie L. Ellis, RHIT, CHP; Lisa Simonson Maiuro, MSPH, Ph.D.

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Counsel; Beth Herse, Senior Staff Counsel; John Kriege, Acting Deputy Director, Healthcare Information Division; Joseph Parker, PhD, Director, Healthcare Outcomes Center; Jonathan Teague, Manager, Healthcare Information Resources Center; Starla Ledbetter, Data Projects Manager; Candace Diamond, Manager, Patient Discharge Data Section; Elvira Chairez, Rural Health Policy Council; Robert Springborn, PhD, Research Scientist II, CABG Program; Merry Holiday-Hanson, Research Scientist Supervisor I; Mallika Rajapaksa, PhD, Research Scientist II; Brian Paciotti, PhD, Research Program Specialist II; Holly Hoegh, Manager, Clinical Data Program

Approval of Minutes: A motion was made by Commissioner Brien and seconded by Commissioner Royer to approve the minutes of the June 9, 2008 meeting. The motion was carried.

Chairperson's Report: Vito Genna, Chair

Chairperson Genna began his comments by noting that Centers for Medicare and Medicaid Services (CMS) will be requiring sprinklers be added in all long-term care facilities within the next five years. This mandate will add to the OSHPD's workload and will be a significant expense to the facilities. Chairperson Genna expressed his confidence that OSHPD will help facilitate this procedure through standardization during this retrofit procedure.

Chairperson Genna stated he wanted to make several comments before Commissioner Royer, in his capacity as Technical Advisory Committee Chairperson, reported on the proceedings at the August TAC meeting. At that meeting, an individual became very directed in the desire to push OSHPD into studies that ushered from a certain set of pre-existing conclusions. Chairperson Genna stated that he wanted to caution those gathered at the current meeting that historically OSHPD has followed a model which started with data, followed by study and analysis, and then ultimately, conclusion. The discussion at the TAC was no doubt a good discussion, but there must be caution exercised in choosing how OSHPD studies are structured from inception to conclusion.

OSHPD Director's Report: David M. Carlisle, MD, PhD

Director Carlisle stated that initial phase of the move to the R Street location which will ultimately consolidate all OSHPD's Sacramento operations under one roof has been accomplished and the current and final phase will be completed with the addition of Facilities Development and Cal-Mortgage. The new location of the Office at R Street has been well received and it will certainly be good to have all the various units of the Department together where staff can easily interact with each other.

The budget impasse continues to figure prominently for the Department, Sacramento and indeed the entire State of California. We are now approaching the 60-day threshold and Governor Schwarzenegger has just issued a proposal for solving the budget impasse which he has sent to the legislature for them to contemplate. This is an unprecedented action, as historically a Governor has waited for a legislative proposal to be presented to him.

The budget impasse is hitting OSHPD in several ways. Regular staff is facing the prospect of being paid minimum wage. All contracts within the State of California have been suspended with only a few exceptions. Fifty-five students, numerous retire annuitants, and intermittent employees have had their work suspended until further notice. This represents a significant impact on the Office. OSHPD has received an exemption for the contracts pertaining to hospital plan review which represents millions of dollars per day in construction.

CHPDAC recently heard a report from John Gillengerten, Deputy Director of Facilities Development Division (FDD) on the activities of that Division. FDD has seen an unprecedented 250 percent increase in building applications coming through that Division this year as compared to last year. The volume of work has not increased as much as has the size of the projects. So OSHPD is seeing major hospital construction projects, rebuilds and new hospital construction. OSHPD is being aggressive in approving projects and working diligently to make sure that timelines are being met.

Legislative Report: Patrick Sullivan, Assistant Director, Legislation & Public Affairs

The budget impasse is currently having an impact on the legislators in this the last week of the legislative session. There are many bills still on file and it seems that it will be hard for them to address them given the current set of circumstances.

A few bills of note:

AB 2966—Originally this bill was going to have a major impact on the FDD hospital inspector program but it did not make it through Committee as drafted and was significantly amended to study the hospital inspector program in an attempt to come up with ways to improve that process.

AB 994—This bill extends the sunset date for the existing nursing scholarship program. This bill may not go forward.

AB 2439—This bill would implement a mandatory $25 fee from physicians and surgeons to help fund scholarships through the Stephen Thompson program.

SB 1272—This bill would help small projects gain better access to capital through Cal-Mortgage by increasing the small loan cap from five million to ten million.

AB 2967—This bill would create a new Commission which would do essentially similar work to what the CHPDAC is currently doing. It would create a Commission charged to put together a cost, quality and transparency plan.

The Commission would have a 16-member body drawn from hospitals, healthcare providers, health plans, employers, labor and consumer groups appointed by the Senate, Assembly and the Governor which would report to the Agency Secretary. The bill requires that the Commission to come up with a plan within a year containing various strategies to measure and collect data related to healthcare safety, quality, utilization, health outcomes and the cost of healthcare services.

In a previous iteration of the bill the CHPDAC was to sunset in July of 2009 and all of its authorities would revert to the new Commission. The latest version was amended to put the CHPDAC back in as it exists today and the two Commissions would co-exist.

The bill's author, Senator Lieber, has stated that other states have extensive reporting on healthcare and quality and the author states we need to update our existing

healthcare quality and cost reporting. The sponsor's comments are more pointed, stating that the current cost and quality data reporting system is antiquated and slow to respond to current needs and it is in a format that is so outdated that skilled researchers are needed to assess and understand it. They go on to state that, whereas the current system is dominated by health industry representatives, the bill would give employers, consumers and labor unions a leading role in the update and design of the health plan reporting system.

The bill currently passed the Assembly and is sitting on the Senate floor waiting to be heard.

OSHPD's position remains neutral on the bill.

HDPIC Chairperson Fine asked in what ways the two Commissions would differ.

Mr. Sullivan stated that the two Commissions appear to be roughly parallel because the new Commission would not only address cost but would be involved with reporting in the manner as the CHPDAC. From the author's perspective, the unique function could be seen as the inclusion of cost information about procedures which would require legislation to gain access to that information.

Chairperson Genna asked if this Commission would be funded from the Data fund which funds the CHPDAC and if so, would there not be an increase in expenditure.

Mr. Sullivan stated that in Appropriations Committee the contention was that there would be no fee increase, but the cap is increased. At some point down the road there would potentially be a fee increase to cover the cost of implementing the activities of the new Commission.

Committee member Nixon stated, "I think CHPDAC has done a great job, and I think they continue to fulfill their mission. There has to be a recognition that the ability for CHPDAC to provide guidance to the Office and for the Office to be able to implement is a total issue related to budget. So, if the funds are not there to be able to do the things the Commission put out there, if this new Commission were enacted, they would face the same financial issues. Without those budgeted funds, you can only go so far. I know over the years the Office has done a great job of even going to the Department of Finance to present the need for additional funding to make the system more transparent and to upgrade the system so they can meet real time expectations. And those funds have never been forthcoming, so to change the composition of the Commission which is obviously the sponsor's intent here, without the budget, it will never happen."

Commissioner Greenfield stated that in looking at the language contained in the bill regarding current healthcare costs, "Until somebody can define exactly what they mean by "cost", there isn't anything to study. You can gather all the data in the world, but what does the cost mean? The cost to whom: the consumer, the hospital, the insurance company?"

Chairperson Genna asked former Executive Director of the CHPDAC, Jacquelyn Paige, if it is within the authority and scope of the CHPDAC to change the name of the HDPIC to incorporate healthcare cost and transparency into the name and the mission of that Committee as those words and issues currently seem to have great resonance both publicly and politically.

Committee member Paige stated that the Commission has the discretion to create or sunset committees. The committees serve at the Commission's pleasure.

Commissioner Moseley commented that the real concerns of the unions are more related to the issue of the timeliness of the data and whether or not the data on cost really relates to quality and the unions are also concerned with whether or not the data is being presented in a manner in which consumers can really understand and use.

Chairperson Genna agreed that there is the perception that information has been slow in coming. This is why he would like the CHPDAC to discuss the title and mission of the HDPIC, in the event that the AB 2967 does not pass, so as to see if some of the concerns of the sponsors of the bill might be addressed through the existing Commission and its subcommittees.

AB 524 Technical Advisory Committee Report: Jerry Royer, MD, Chair

Commissioner Royer began by stating that there were a number of important presentations at the last TAC meeting, each generating strong discussions. Commissioner Royer respectfully disagreed on the matter of one individual pushing OSHPD in a certain direction with regard to future studies. There were four Committee members who spoke, perhaps not as passionately at as the member in question, but certainly in the same direction regarding appropriateness studies.

Commissioner Royer stated that this may be the first time, at least in his tenure as Chairperson of the TAC, that there has been this extent of disagreement between the TAC and CHPDAC as has been the case with the discussions around the topic of appropriateness studies.

Commissioner Royer characterized the reaction of the TAC as one of surprise and frustration at the recommendation taken by CHPDAC not to pursue the appropriateness study on Percutaneous Coronary Interventions (PCI's). The TAC asked for an opportunity to educate the CHPDAC with a presentation on the science of appropriateness studies. There is a 25-year history of appropriateness studies. The TAC further asked that the Office review the science of appropriateness as an outcomes measure for PCI. Lastly, TAC asked the Office to look at whether the outcomes net could extend to include an appropriateness study without statutory action.

Congestive Heart Failure

Commissioner Royer reported that during the discussion on the Congestive Heart Failure (CHF) Outcomes Report, particular attention was focused on the time period of

follow-up with regard to mortality in the study; 30 day, 60 day, 90 day, 180 or 365 day. The concern expressed by the TAC members was that the follow-up is so critical. How much of that can or do hospitals perform in terms of regular follow-ups to keep the patient out of admissions? So the members wanted to look at if the mortality rate was different at these different time intervals. Upon examination, it was concluded that there basically is no substantive difference, so the recommendation from the TAC was to go back to the 30-day mortality measure. To illustrate the magnitude of CHF, the in-hospital mortality rate is 4.6 percent and the 30-day mortality rate is 9.88 percent.

A couple of preliminary conclusions from the CHF report:

- The better hospitals have slightly sicker patients.
- The better hospitals are more likely to accurately code present on admission (POA).
- There appears to be some concordance between the OSHPD CHF model and CMA's model given that CMA model for identifying outliers is more conservative than OSHPD's model.

The TAC voted to approve the risk model and methods for generating hospital level results for public reporting.

Commissioner Royer moved that the risk model and methods for generating hospital level results for a public reporting on CHF be approved by the CHPDAC. Commissioner Greenfield seconded. Motion carried.

Abdominal Aortic Aneurysm

Commissioner Royer reported that during the discussion on Abdominal Aortic Aneurysm (AAA) Repair, the recommendation was to report on open and endovascular procedures excluding rupture cases.

Dr. Parker stated that this study is using data spanning a three year period:

- 218 hospitals performed at least 1 open or endovascular abdominal aortic aneurysm procedure
- 84 hospitals had 30 or more cases
- 59 hospitals had 10 to 29 cases
- 75 hospitals had less than 10 cases
- 51 hospitals had 1 or fewer cases

The range of mortalities in this study is from 0 to 10 percent.

The TAC voted to approve AAA as a procedure for a risk-adjusted outcomes report and to approve the AAA risk model and methods for generating hospital level results for public reporting.

Commissioner Fine asked if there was going to be an indication of the number of ruptures that are not included in that report.

Dr. Parker stated that currently the thought was that the report would exclude patients that present with rupture.

Commissioner Fine stated that part of the reason patients present with rupture is because they were not cared for properly before they ruptured. "I think that the denominator needs to be a real number, because right now you are giving us two options for elective treatment of aneurysm, but you are not giving us the total prevalence of the disease. I think that is an important part of the report."

Commissioner Royer moved to approve AAA Repair as a procedure for a risk adjusted outcomes report and approve the risk model and methods for generating hospital level results for a public report on AAA to include the cases being measured, endovascular and open repairs, and also include in the denominator the number of rupture cases. Commissioner Greenfield seconded. Motion carried.

Proposal to add elements to the Office's patient-level data reporting programs: Starla Ledbetter, Data Projects Manager

In looking at the 14 data elements currently being considered for addition to the patient-level data reporting programs, information gathered through a hospital survey containing the following kinds of information was analyzed:

- What do hospitals currently capture electronically vs. on paper?
- For the clinical data elements, what are the definitions used, the units reported in and the format the results are displayed in?
- Preference for implementation.
- Status of electronic health record implementation.

The hospital survey containing 99 questions was sent to 448 hospitals of which 164 responded. The hospital survey results:

Lab Values
- Over 90% agree with our proposed definitions; 80% agree with format and units

Vital Signs
- Over 95% agree with the proposed definitions, reporting units and format
- The majority of hospitals record vital signs in the paper record

Identification of Transferring Facility
- 70% record name of facility transferred from
- 85% record name of facility transferred to
- Less than half store the name of the transferring facility electronically

Some hospital concerns are:

- Cost of abstracting data not yet stored electronically
- Purpose and use of data elements needs to be clearly stated
- Cost of system changes

- Need for at least one year lead time before new data collection is started

The proposed order of collection will be:

- Begin with Patient Address Indicator and Lab Values
    - Readily available electronically
- Future: Add Vital Signs when Electronic Health Records are more prevalent
- Future: Add Operating Physician identifier
    - Additional analyses required for procedure selection

Proposed New Data Elements (14):

- Aspartate Aminotransferase (AST)
- Potassium
- Sodium
- pH
- International Normalized Ratio (INR)
- Albumin, serum
- Creatinine
- Blood Urea Nitrogen (BUN)
- Platelet Count
- White Blood Cell Count
- Hemoglobin
- Glucose
- Oxygen Saturation
- Patient Address Indicator

Implementation Timeline

- Draft regulation package to HDPIC January 2009
- Draft regulation package to CHPDAC February 2009
- Regulation adoption (best case) September 2009
- MIRCal system modification—12 months after regulation adoption
- Begin collection January 2011

Commissioner Fine asked how glucose ended up back on the list after the decision had already been made by the CHPDAC to remove it.

Dr. Parker stated that was a decision that was made by the Office. There were initially 18 data elements being considered which included vital signs, but it became apparent that it would be difficult to collect vital signs considering the difficulties present in defining them and given that there are no national standards available. Therefore the Office has chosen to move forward with laboratory data which opened up several slots for alternate or new lab values to be considered. The thought behind this decision was that it has taken some time to arrive at this point and we would like to get as close to the 15 data element limit allowed for a five year period.

Commissioner Fine asked why maximizing the amount of data elements at this time is an issue if data elements can be added at a later date to reach the 15 element limit.

Dr. Parker stated that given the length of time this process takes, it was thought that if there were other elements that could add value that it would make sense to go forward with them now.

Mr. Kriege stated that although glucose had not made it onto the recommended list from the initial presentation to the CHPDAC, weighing both its public health value and the fact that glucose was something that hospitals did keep in the record electronically, it was decided to put glucose back on the list.

Commissioner Brien stated, "When we went over this before we were very clear regarding glucose. Both of the investigators, Dr. Pine and Dr. Bindman who presented their reviews of the data elements being considered, had glucose as being something that did not correlate with any expected outcome. So even though there may be some open data element slots, I am not sure why you would throw something in that clearly was not correlating with patient outcomes, morbidity and mortality. It would be better to leave the slot open and add something in the next year or two as more information becomes available. So the question would be if you are adding in glucose, what are you looking to assess? The state of the diabetic? In that case, there are other measures that are more valid and glucose has very little value as a lab test on admission in that regard."

Commissioner Fine stated that both the researchers indicated that glucose was useless as an indicator when it's done as a random measure, just one point in time. It is not predictive of anything. It is not predictive of obesity. It is not predictive for diabetes.

Dr. Parker clarified that the researchers had stated that it was a significant predictor in 4 of the 11 models they looked at, but having stated that, there are data elements that we did not choose that are predictive of more mortality than glucose.

Commissioner Moseley stated, "I spoke to this before, but I think it should be reiterated. I understand that glucose is not a predictor, but I think in this country obesity is prominent in the news. We encourage people to find out if they have diabetes or not. I think it would be interesting to find out, if glucose is added as an element, to track how many people go to the hospital with elevated glucose and later do develop diabetes even though it is not considered a predictor. I think from a public health perspective it would be good to show that this Commission is looking at this."

Commissioner Brien stated, "While I do agree that both obesity and diabetes are public health issues, I go back to the science of the indicators and what we are actually looking at when we try to come up with elements that will be predictive of morbidity and mortality and glucose is just scientifically not a predictor."

The HDPIC took a vote to recommend by consensus that glucose be removed from the list of data elements being considered by the Office. Five members voted aye with one abstention.

Commissioner Greenfield moved that Glucose be removed from the list of 14 data elements. Commissioner Brien seconded. Six Commissioners voted aye. Commissioners Sanchez and Moseley voted nay. Commissioner Karkia abstained. Motion carried.

Commissioner Brien moved that the Office go forward with the list of 13 data elements to develop regulation package. Commissioner Royer seconded. Motion carried.

AHRQ Quality Indicators: John Kriege, Acting Deputy Director, HID; Joseph Parker, PhD, Director, HOC; Jonathan Teague, Manager II, HIRC

A previous report to the Commission addressed the methodology being used to produce two OSHPD population-based studies, *Racial and Ethnic Disparities in Healthcare* and *Preventable Hospitalization in California*, which are based on the use of AHRQ Quality Indicators. The methodology used to produce these reports is based on the full range of the Prevention Quality Indicators and a small subset of the Pediatric Quality Indicators. Both reports were covered in some detail at the previous meeting, the current presentation will drill down into the Quality Indicators.

Background on Quality Indicators:

- Developed as a tool for measurement, improvement of care
- Reliance on readily available, largely uniform administrative data sets
- Providers, policymakers, and researchers can use with inpatient data to identify apparent variations in quality of inpatient or outpatient care

Development of Quality Indicators

- Major constraint: measures could require only the type of information found in hospital discharge abstract data
- Data elements required by the measures had to be available from most inpatient administrative data systems
- Measures based on a "common denominator" discharge data set, without the need for additional data collection.
    - Results in a tool that could be used with any inpatient administrative data, thus making it useful to most data systems.
    - Enables national and regional benchmark rates to be provided using HCUP data

Quality Indicators Organized into Four Modules

- Prevention Quality Indicators (PQIs)
    - Focuses on preventive care services—outpatient services geared to staying healthy and living with illness

        - General agreement among researchers and policymakers that inpatient data offers useful window on the quality of preventive care in the community
    - Inpatient data provide information on admissions for “ambulatory care sensitive conditions”
        - Significantly avoidable through better outpatient care.
    - Data can identify community need levels, target resources, and track impact of programmatic and policy interventions.
- Inpatient Quality Indicators (ISIs)
- Patient Safety Indicators (PSIs)
- Pediatric Quality Indicators (PDIs)

Prevention Quality Indicators:

- PQI 1-Diabetes short term complication admission rate
- PQI 2-Perforated appendix admission rate
- PQI 3-Diabetes long-term complication admission rate
- PQI 5-Chronic obstructive pulmonary disease admission rate
- PQI 7-Hypertension admission rate
- PQI 8-Congestive heart failure admission rate
- PQI 9-Low birth weight
- PQI 10-Dehydration admission rate
- PQI 11-Bacterial pneumonia admission rate
- PQI 12-Urinary tract infection admission rate
- PQI 13-Angina admission without procedure
- PQI 14-Uncontrolled diabetes admission rate
- PQI 16-Rate of lower-extremity amputation among patients with diabetes
- PDI 14-Asthma admission rate
- PDI 16-Gastroenteritis Admission rate

Examples:

- PQI 1—Diabetes short-term complication admission rate
    - Patients with diabetes may be hospitalized for diabetic complications if their condition is not adequately monitored or if they do not receive the patient education needed for appropriate self-management.
- PQI 2—Perforated appendix admission rate
    - Patients with appendicitis who do not have ready access to surgical evaluation may experience delays in receiving needed care, which can result in a life-threatening condition—perforated appendix
- PQI 15—Adult asthma admission rate
    - Patients may be hospitalized for asthma if primary care providers fail to adhere to practice guidelines or to prescribe appropriate treatments.

Two Companion Reports, *Racial and Ethnic Disparities in Healthcare* and *Preventable Hospitalization in California*:

- Looking at the same data and indicators
- Stratification in two different dimensions (population group and geography)
- Address two (related) sets of questions
    - Equity in access to care, in terms of race and ethnicity
    - Equity in access to care, in terms of geography, disparate community resources, particular local burdens of disease

Racial and Ethnic Disparities:

- Examine data 1999-2007 (most recent)
- Describe & illustrate differences (disparities) in healthcare in California
- Apply statistical significance tests
- Population groups:
    - Asian/Pacific Islander
    - Black
    - Hispanic
    - Native American
    - White
    - Other

Preventable Hospitalizations in California:

- Descriptive analysis focusing on geographical variations
- County-based; investigating MSSA-based
- Statewide trends in printed form
- County (and potentially MSSA) trends via web-based distribution due to volume
- Complement trends with map-based presentation

The target date for completion of the *Racial and Ethnic Disparities in Healthcare* and *Preventable Hospitalization in California* reports is October 2008.

Hospital Inpatient Mortality Indicators for California: David M. Carlisle, MD, PhD; Joseph Parker, PhD, Director; Brian Paciotti, PhD; Merry Holliday-Hanson, PhD, HOC

This presentation involves another subset of the AHRQ indicators, specifically the Inpatient Mortality Indicators.

OSHPD started discussing the reporting of hospital quality measures in California. The first legislation that gave the Office the authority to produce hospital quality measures was AB 524 that was enacted in 1991. This legislation gave the Office a projected timeline for the release of data products. The Office was to have produced three reports by 1993, by 1995 six reports and by 1997 nine reports which was the threshold of the AB 524 timeline.

The Office's actual productivity is quite different. Until the year 2001, the Office had only produced one outcomes report, Acute Myocardial Infarction (AMI). The Office added Coronary Artery Bypass Graft (CABG) to the portfolio in 2001, but some may argue that CABG may not be a report covered by AB 524 because it is being conducted

with clinical data instead of administrative data. Around 2004, the Office added Community Acquired Pneumonia (CAP) and currently the Office is working on three additional reports: Congestive Heart Failure (CHF), Abdominal Aortic Aneurysm Repair (AAA) and Maternal Birth Outcomes (MBO). We expect that these reports will be released next year, but that would only bring the Office up to six reports instead of nine.

Director Carlisle stated that this is why the Office has received criticism for not meeting the statutorily defined deadlines. The Office recognizes the meaningfulness of the criticism and indeed, that is in part what led to the AB 2967 legislation by Senator Lieber that has called for increase productivity from the Office. If the Office was to move forward and produce the AHRQ Inpatient Mortality Indicators, and the Office has already generated the results for 2007 for immediate release, the Office would then be producing hospital quality studies for up to 14 Indicators by 2009. This represents a huge increase in production volume for the Office and allows the Office to meet the original statutorily defined production guideline and in fact, to exceed it to a significant degree.

Why AHRQ Inpatient Mortality Indicators:

- Developed by the Agency for Healthcare Quality and Research
- Several endorsed by the National Quality Forum
- Already used by 9 states for rating individual hospitals performance
- Enhanced by incorporation of condition present on admission (CPOA) codes
- Allow rapid production of ratings
- Consistent with Governor Schwarzenegger's call for increased healthcare transparency and quality reporting

Overview: AHRQ Inpatient Mortality Indicators (IMIs)

- Include 15 "procedures and conditions for which mortality has been shown to vary across institutions and for which there is evidence that high mortality may be associated with poorer quality of care"
- Use patient discharge data
- Software available without cost
- APR-DRG Risk model not "black box" anymore
- Historically, OSHPD and its advisory committees have argued against publication of IMIs

AHRQ Message on IMI Validity:

- Providers, policymakers, and researchers can use with inpatient data to identify apparent variations in the quality of inpatient care
- Although quality assessments based on administrative data cannot be definitive, they can be used to flag potential quality problems and success stories, which can then be further investigated and studied

- Hospital associations, individual hospitals, purchasers, regulators and policymakers at the local, State, and Federal levels can use readily available hospital administrative data to begin the assessment of quality of care

OSHPD Message on IMI Validity:

- OSHPD views these indicators as potentially useful starting points for examining hospital quality but does not regard them as definitive measures of quality. When this information is carefully considered, with its limitations, alongside other reliable healthcare provider information, it may be helpful to patients and purchasers when making decisions about healthcare treatment choices. Healthcare providers also benefit from using this information in quality improvement activities.

OSHPD Internal Validation of IMIs:

- Do hospitals with a large percentage of DNR, palliative care, or SNF patients fare worse than other hospitals, on average?
- Do hospitals with sicker patients (higher expected mortality) fare worse than other hospitals, on average?
    - Do hospitals that code POA poorly (rarely code complications) fare better than other hospitals, on average?
- Do certain types of hospitals (teaching, public, profit, non-profit) fare worse than other types of hospitals, on average?
- Does the AHRQ inclusion of POA improve original IMI by bringing it closer to a gold standard proxy?

Summary of Internal Validation Analyses:

- Some patient's illness severity is not explained by APR-DRG risk model (true of OSHPD Traditional models as well)
- No clear bias found in hospital performance based on average severity of patient illness prior to hospitalization of POA coding practices
- Government hospitals had higher mortality rates for some IMIs, on average, and teaching hospitals had somewhat lower mortality rates for some IMIs
- Implementation of POA coding improves assessment of hospital quality relative to a CABG gold standard proxy

Commissioner Brien moved that the Office go forward with the 8 AHRQ Inpatient Mortality Indicator studies. Commissioner Sanchez seconded. Motion carried.

Next Meeting: The next meeting will be held on October 24, 2008 in Sacramento, California.

Adjournment: The meeting adjourned at 1:26 p.m.

Pending Items:

1. Commissioner Karkia requests a special session of the CHPDAC to discuss various issues pertaining to the functions of the Commission.